PATIENT CONSENT FOR TREATMENT

Consent to Medical and Surgical Procedures: I give my consent to all the medical procedures which may be performed upon me by the Hospital, on either an inpatient or outpatient basis, which are ordered or prescribed for me by my attending physician. This may include but is not limited to: laboratory procedures, x-ray examination, diagnostic procedures, medical, nursing or surgical treatment or procedures, anesthesia, or hospital services rendered to me under the general and special instructions of my physician.

Consent to Imaging/Diagnostic Procedures: I give my consent if the attending physician believes it is beneficial for me to undergo one or more of the following exams that produce ionizing radiation: diagnostic X-rays, Computed Tomography (CT), and the use of Fluoroscopy while undergoing an injection, surgical or pain procedure. Although both short and long-term risks are present with radiation exposure, this rarely results in significant short or long-term injury. In complex cases, local tissue damage to the skin or even underlying layers may occur that may require additional follow-up treatment.

Consent to Draw Blood/Emergency Procedures: I hereby consent to the withdrawal of a blood sample in the event an employee or contractor of the hospital has a needle stick or mucous membrane exposure to my blood or body fluids. I further consent to the medical treatment from a licensed physician in the event of a highly urgent or emergency event in which the patient, a family member, or other responsible party cannot reasonably be reached to authorize treatment.

Authorization for Use or Disclosure of Protected Health Information (*please initial and check choice, if applicable)*

______ I hereby □ DO or □ DO NOT authorize the use of audio/video record or broadcast of my surgery and disclosure of individually identifiable health information relating to me as described below.

______ I further □ DO or □ DO NOT authorize physical observation of my surgery by medical personnel and appropriate manufacturer's representatives or other observers as determined by my physician.

_______I (we) authorize my surgeon the use of photographs in the interest of my medical record.

- The above information will be called "*Authorized Information*" throughout the rest of this Authorization.
- The *Authorized Information* will be used by the physician performing my surgery and by other individuals as determined by my physician.
- The *Authorized Information* can be disclosed for informational and/or instructional purposes.
- This *Authorized Information* can be used when all identifying information have been removed, to instruct in a clinical environment or for research purposes in accordance with applicable privacy rules.
    - I understand that if the person or entity receiving *Authorized Information* is not a health plan or health care provider covered by federal privacy regulations, the *Authorized Information* may be re-disclosed by the recipient and may no longer be protected by federal or state law.
    - I understand that I may revoke this authorization at any time by notifying the Business Office Manager of North Central Surgical center in writing. However, if I choose to do so, I understand that my revocation will not affect any disclosure allowed by this Authorization before the receipt of my revocations.
    - I understand that I may refuse to sign this Authorization and that my refusal to sign in no way affects my treatment.

Release of Information: I authorize the Hospital and any physician involved in my care to release medical information and supporting documentation of same as compiled in my medical records during this admission or outpatient visit to any organization which is or may be liable or responsibly for payment of charges associated with my care and for all other purposes of benefit payment. If my injury is work-related, I authorize the Hospital to release any information from my medical records to my employer and/or its designee.

In compliance with the State Medical Device Act of 1990, if an FDA designated medical device is implanted during surgery, I (we) understand that my Social Security number and name will be released to the manufacturer.

______ I (we) understand that my name and procedure will be posted on the OR Scheduling board in a private area of the Operative Suite.

DO YOU HAVE ADVANCE DIRECTIVES? ☐ Yes ☐ No If yes, where is it located? ____________________

______ I (we) understand that in the event surgery is performed and circumstances arise necessitating resuscitative measures, the Surgeon, Anesthesiologist, and employees of North Central Surgical Center will employ all necessary methods to resuscitate.

______ **Valuables and Personal Items:** I (we) agree to assume full responsibility for items I bring such as money, jewelry, other valuables, or personal items such as dentures, eyeglasses, hearing aids, contact lenses, etc.

______ I am of sound mind and capable of and have in fact reviewed the following information and I am hereby voluntarily initialing this Consent. The following information has been provided to and explained to me: **(1) the danger of failing to inform the medical providers of, and/or failing to remove any body piercing and/or other metal artifacts, in or on one's person, prior to the procedures discussed.**

______ **Physician Ownership Acknowledgement (*please initial*):** North Central Surgical Center meets the definition of "physician-owned hospital" under 42 CFR 489.3. The hospital may be owned in part by your physician. You have the right to choose the provider of your health care services. Although we believe that North Central Surgical Hospital will be able to meet your needs, you have the option to use a facility other than ours. You will not be treated differently by your physician if you choose to use a different facility; however, your physician may not be able to perform your procedure(s) at such facility. If desired, your physician or staff member can provide information about alternative health care providers. If you have any questions concerning this notice, please feel free to ask your physician or an administrative representative of North Central Surgical Center. This information is being provided to you to help you make an informed decision about your health care.

______ I acknowledge that one or more of the physicians providing treatment at North Central Surgical Center may have ownership interest in North Central Surgical Center. I also acknowledge that I have the right to choose the provider of my healthcare services and I have chosen North Center Surgical Center.
I acknowledge that a current listing of physician partners at North Central Surgical Center is available upon request.

I have ☐ **RECEIVED** -or- ☐ **DECLINED** this listing. (*check box*)

______ **Patient Rights:** I have received a copy of the "Patient's Rights and Responsibilities."

______ I ☐ **DO** or ☐ **DO NOT** want the hospital to notify a family member/representative and/or my physician in the event of my admission.
Contact Information:
Family/Representative Name:____________________ Phone:____________________
Physician Name: ____________________ Phone: ____________________

DOCUMENTATION OF GOOD FAITH EFFORT

The patient identified was provided with a copy of the provider's Privacy Notice on the date. A good faith effort has been made to obtain a written acknowledgement of patient's receipt of the Privacy Notice. However, acknowledgement has not been obtained because:

______ Patient refused to sign the Privacy Notice Acknowledgement.
______ Patient was unable to sign because: ____________________
______ There was a medical emergency. Provider will attempt to obtain acknowledgement as soon as practical.
______ Other reasons: ____________________

______ **Confidential / No Information Patient:** I understand that if I request to be registered as a Confidential / No Information Patient my presence will not be acknowledged other than to my caregivers and those with a need to know.

______ **Pediatric Patients (under the age of 18 years old):** A parent/legal guardian must provide consent for medical treatment of a minor-

aged patient. Any pediatric patient requiring hospitalization must be accompanied by a parent/legal guardian at all times.

______ **Sensory or Physical Impairments**: I understand the hospital has resources to meet special needs for patients with sensory or physical impairments. I have the following special needs: ____

____

****

______ **MEDICARE patients only (*please initial)***: If this is an admission, which is covered by Medicare, I will receive a copy of "An Important Message from Medicare" furnished by North Central Surgical Center.

****

Non-Smoking Policy: In accordance with regulatory agency standards, North Central Surgical Center is a non-smoking facility.

Financial Agreement: The undersigned agree(s), whether he/she signs as agent or patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligated himself/herself to pay the account of the Hospital for services in accordance with the regular rates and terms of the Hospital. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay attorneys fees and collection expenses actually incurred. I further acknowledge that all physicians furnishing services including but not limited to radiologist, pathologist, anesthesiologist, consultants and assistants to the physician are independent contractors and not employees of the hospital. I understand that I may receive separate billing from each of these providers for services rendered.

Assignment of Insurance Benefits: I hereby authorize payment directly to North Central Surgical Center and all attending physicians of the insurance benefits specified and otherwise payable to me but not exceed the Hospital's regular charges for these services. I understand that I am financially responsible to the Hospital for charges not covered or disallowed by the assignment.

I (we) certify this form has been fully explained to me, that I (we) have read it or have had it read to me (us), that the required blank spaces have been filled in, and that I (we) understand its contents.

____ ____________ / ____________ AM/PM

PATIENT SIGNATURE OR LEGALLY RESPONSIBLE PERSON DATE TIME

____ ____

WITNESS SIGNATURE SIGNATURE OF LANGUAGE ASSISTANCE REPRESENTATIVE (IF APPLICABLE)

PATIENT HEALTH INFORMATION REQUEST FORM

At which of the following number(s) do we have permission to contact you?

☐ Home ______________________________ ☐ Work ______________________________

☐ Cell Phone __________________________ ☐ Other ______________________________

May we leave a message for you: at work? ☐ Yes ☐ No at home? ☐ Yes ☐ No cell? ☐ Yes ☐ No

Other than you or your insurance, whom may we talk to about your healthcare information?

NAME	PHONE NUMBER	RELATIONSHIP

In order to verify accurate health information before your imaging procedure, we will be going over the forms you completed in the waiting area and may need to ask you some additional questions, prior to entering the procedure room. While we will make every effort to respect your privacy, it is possible that you may be seen or overheard by other patients/family members. Will this be a problem for you?
☐ Yes ☐ No

Do you have any health information that you would like kept confidential from any person or persons?

☐ Yes **☐ No** ☐ If so, please describe:

____

____

_______ I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information. I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

____

Would you like to designate a support person/patient representative? **☐ Yes** **☐ No**

If yes, list name of designated individual:____

_______ I understand that by designating this individual as my support person/patient representative, I am hereby giving permission to share my protected health information with the designated individual.

- Your support person/patient representative may remain with you throughout your hospital stay, with the following exceptions:
  - During a treatment or procedure
  - In a medical emergency, at the physician's discretion

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that North Central Surgical Hospital, its legal agents, or affiliates may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service or leave a voice message on an answering device. If an email address has been provided, North Central Surgical Hospital, its legal agents, or affiliates may contact me with an email notification regarding my care, our services, or my financial obligation.

____

Patient/Patient Representative Signature **Date** **Time**

State Required Ethnicity and Race Questions

BACKGROUND INFORMATION

Texas law requires the Texas Health Care Information Council to collect information on the race/ethnic backgrounds of hospital patients. Hospitals are required to ask patients to identify their own race and ethnic backgrounds.

The data obtained through this process will be used to assist researchers in determining whether or not all citizens of Texas are receiving access to adequate health care.

If patients fail or refuse to identify their own race and ethnic backgrounds, facility staff will use its best judgment in making the identification.

QUESTIONS

Question #1: Nationality or Ethnic Background

(mark the box that most accurately identifies the patient's ethnic background)

Is the patient . . .?

- ☐ **(1) Hispanic/Latino** (21352)
- ☐ **(2) Not Hispanic/Latino** (21865)
- ☐ **I (patient or patient's legal guardian) refuse to answer the question.**

Question #2: Race

(mark the box that the patient believes most accurately identifies his/her race)

Is the patient . . .?

- ☐ **(1) American Indian/Eskimo/Aleut** (10025)
- ☐ **(2) Asian or Pacific Islander** (20289)
- ☐ **(3) Black** (20545)
- ☐ **(4) White** (21063)
- ☐ **(5) Other** *Includes all other responses not listed above. Patients who consider themselves as multiracial or mixed should choose this category.* (21311)
- ☐ **I (patient or patient's legal guardian) refuse to answer the question.**

Patient or Legal Guardian Signature:________________________ **Date:**____________________

Patient History Form

1. What **part of the body** are we imaging/injecting today? ______________________________
2. Please describe your **symptoms** relating to the body part we are imaging: ____________________
   How long have you had these symptoms and/or pain? ______________________________
   Location of your pain and/or does your pain move or radiate to another part of the body?
   ____
3. Please explain if you have limited range of motion. ______________________________
4. Was this due to an **accident, fall or trauma**, please provide details and **how long ago**? ______________
   ____
5. Have you had **previous Surgery to the part of the body we are imaging today**? If **yes**, please provide the **type of surgery and date**. ______________________________

FALL ASSESSMENT:

Have you fallen in the last 3 months? ☐ Yes ☐ No

Do you experience unsteadiness, weakness, dizziness or vertigo? ☐ Yes ☐ No

Do you use a cane, walker or wheelchair? ☐ Yes ☐ No

Do you have trouble remembering, learning new things, concentrating or making decisions? ☐ Yes ☐ No

FEMALE PATIENTS only: **Pregnancy Screening** (11 years – 60 years old):

Have you had a hysterectomy (removal of the uterus)? ☐ Yes ☐ No ☐ N/A

Do you have any reason to believe you might be pregnant? ☐ Yes ☐ No ☐ Unsure ☐ N/A

Are you currently breast feeding? ☐ Yes ☐ No ☐ N/A

If there is a remote possibility of pregnancy, you will be asked to have a pregnancy test prior to any exam involving an X-ray, CT or MRI or you have the option to refuse the pregnancy test and sign a waiver.

Educational Note: The Imaging center has (3) Magnetic Resonance Imaging (MRI) scanners. In order to provide a safe environment, we'd like to inform you of the following **MRI Zones** within the area.

Zone 1 = Main patient waiting room or outer hallways of the hospital.
Zone 2 = Unscreened patient area, dressing room and bathrooms.
Zone 3 = "Screened" MRI patients/family and authorized personnel. Area directly outside of the MRI Magnet rooms.
Zone 4 = "Screened" MRI patients and family under direction and supervision of trained MRI personnel only.

Please note: **The MAGNET IS ALWAYS ON!**

Patient Signature: ______________________________ Date: ______________

Staff Signature: ______________________________ Date: ______________ Time: __________

Magnetic Resonance Imaging

SCREENING FORM FOR PATIENTS

The information requested on this form is *very important.* Please answer *all* questions as thoroughly as possible. ***The patient or patient's legally authorized representative is responsible for the accuracy of the requested information.*** Do you have any of the items or conditions listed below? Please check YES or NO for each item or condition or provide additional information

YES	NO		YES	NO	
		Aneurysm Clip			Neurostimulation system
		Middle Ear / Cochlear Implant			Bone growth/bone fusion stimulator
		Cardiac Pacemaker			Fractured Bone or Spine treated with Metal
		Implanted Defibrillator			Metal to the Eyes (ex: welding, grinding)
		Stent, Coil or Filter surgically implanted			Metal Fragments in the Body (ex: BB's, Buckshot or Bullet)
		Surgical staples, clips or metallic sutures			Penile Implant
		Artificial Heart Valve			Silver Impregnated Wound Dressing
		Internal Electrode or Wires			Breastfeeding
		Carotid Artery Clips			IUD: Intrauterine Device
		Vascular Access Port or Catheter			Medication Patch
		Magnetically Activated Implant or device			Ingested camera pill
		Medication pump or Implanted infusion pump or Insulin pump			Tattoos or Permanent Make-Up
		Hearing aid			Body Piercing
		Spinal or ventricular shunt			Allergic Reactions to Intravenous (IV) Contrast
		Tissue Expander			Kidney Problems Now or In the Past
		Prosthesis of Any Kind			Patient Weight ___________
		Glucose Monitor			Patient Height ____________

ANY METAL Inside or Outside Your Body As Indicated Above? (Please provide location)

Claustrophobic? Please rate 1 – 10 (10 being severe)

No one should enter the MRI Magnet / Scan room with the following: * watch * metal zippers * firearms * removable dental work * pens * hearing aid * keys * coins * pocket knife * hairpins * belt buckle * bra * purse/wallet/money clip/credit cards * cell phones or other electronic or metallic devices

Signature of person completing the form: ______________________________ Date: __________ Time: ______

Form completed by: ☐ Patient ☐ Relative ☐ Caregiver ☐ Other ______________________________

Imaging Educational Material:

MRI is a scanning technique for creating detailed images of the human body. The scan uses a strong magnetic field and radio waves to generate images of parts of the body that can't be seen as well as X-rays, CT or Ultrasound.

Before my MRI: Please notify the Imaging scheduling team if you have a pacemaker, neurostimulator, artificial heart valve, medication pump, tissue expander, cochlear implant, exposure to BB's, buckshot, bullet fragments, welding or grinding with fragments around the eyes. The clinical staff may need to ask additional questions to make sure you are safe to have a MRI.

What can I expect during my MRI scan?

- The duration will vary but on average the test will take 45 minutes to 1 hour per body part.
- You will be asked to lie still during the MRI scanning.
- The machine is open at both ends. It will be well lit and there is a fan for patient comfort. There is also a 2 way intercom system for communication between the patient and the technologist. The part of the body being scanned will be placed in the middle of the magnet.
- During the actual imaging, you will hear a loud intermittent banging noise. You will be provided with earplugs or head phones (depending on the body part) to minimize the noise during the procedure.
- The technologists will provide you with an alarm button to alert the tech of any issues such as a cough or sneeze that prevents your from holding still or any issues that arise that need immediate attention.
- Some MRI exams require an injection of intravenous MRI Contrast, inform the tech if you experience any discomfort during or after the injection.

Computed tomography or CT scan allows the doctor to see inside your body. It uses a combination of X-rays and a computer to create pictures of your organs, bones and other tissues. It shows more detail than a regular X-ray. You can get a CT scan on any part of your body. The procedure doesn't take very long.

How Do CT Scans work? They use a narrow X-ray beam that circles around one part of your body. This provides a series of images from many different angles. A computer uses this information to create a cross-sectional picture. Like one piece in a loaf of bread, this 2 dimensional scan shows a "slice" of the inside of your body. This process is repeated to produce a number of slices. The computer stacks these scans one on top of the other to create a detailed image of your organs, bones or blood vessels.

During the test, you'll lie on a table inside a large, doughnut-shaped CT machine. As the table slowly moves through the scanner, the X-rays rotate around the body. It's normal to hear a whirring or buzzing noise. Movement can blur the image, so you'll be asked to stay very still. You may need to hold your breath at times.

What is a CT scan with contrast? In a CT scan, dense substances like bones are easy to see. But soft tissues don't show up as well. They may look faint in the image. To help them appear clearly, you may

need a special dye called contrast material. They block the X-rays and appears white on the scan, highlighting blood vessels, organs and/or other structures.

Ultrasound also called sonography, uses sound waves to develop ultrasound images of what's going on inside the body. An instrument called a transducer emits high frequency sound, inaudible to human ears, and then records the echoes as the sound waves bounce back to determine the size, shape, and consistency of soft tissues and organs.

This information is relayed in real time to produce images on a computer screen. The Ultrasound technologist or sonographer has special training in how to perform the test. Then a radiologist will interpret the images. This technology can help diagnose and treat certain conditions.

Doctors employ ultrasound imaging in diagnosing a wide variety of conditions affecting the organs and soft tissues of the body.

Bone Density tests (also called bone mineral density tests) determines if you have osteoporosis – a disorder characterized by bones that are more fragile and more likely to break.

A bone density test uses X-rays to measure how many grams of calcium and other bone minerals are packed into a segment of bone. The bones that are most commonly tested are in the spine, hip and sometimes the forearm.

Myelogram uses a real-time form of x-ray called fluoroscopy and an injection of contrast material to evaluate the spinal cord, nerve roots and spinal lining. It is particularly useful for assessing the spine following surgery and for assessing disc abnormalities in patients who cannot undergo MRI. The radiologist will introduce a spinal needle into the spinal canal and then introduce (inject) the contrast material.

Following the myelogram, you will be taken to CT and additional images will be taken to better define the anatomy and any abnormalities.

Please tell your doctor if you're allergic to iodinated contrast material. You may be advised to stop taking blood thinners or other medication several days prior to your exam.

Steroid Injection works by decreasing inflammation and reducing the activity of the immune system. Steroids are used to treat a variety of inflammatory diseases and conditions.

How are steroids given? Steroids are given locally to the precise place where the problem exists. This allows doctors to deliver a high dose of medication directly to the problem area.

Arthrogram is another type of imaging where first you get a special dye, called contrast, injected into your joint. Then, your doctor uses MRI or CT to take additional pictures. The contrast dye helps highlight what's gone wrong in the joint.